Date: _____

Name _____ Birthdate _____ Chart No. _____

New Patient Intake Form

This form lets us get to know you and know how we can help. Not every question is important to everyone, but the more you can answer, the more we can help. If there is a question that makes you uncomfortable, skip it and discuss it during your visit. Thank you.

Do you need help with this form? ☐ Yes ☐ No

If you answered yes, please stop filling out the form and speak with a Front Desk staff member.

Person filling out this form (if not the patient): _____

Name Relationship to Patient

Reason for your visit today: ☐ Routine exam ☐ Something is bothering me/I have something specific to discuss

for office use only

What medical problems do you have now or have you had in the past? ☐ None

☐ Diabetes	☐ Depression or anxiety
☐ High Blood Pressure/hypertension	☐ Thyroid problems
☐ High cholesterol	☐ Migraines
☐ Hepatitis A	☐ Blood clots
☐ Hepatitis B	☐ Breast disease
☐ Hepatitis C	☐ Allergies
☐ Other liver problems	☐ Asthma
☐ Pancreatitis	☐ COPD or Emphysema
☐ Kidney failure	☐ Tuberculosis (TB)
☐ Cancer	☐ HIV or AIDS

☐ Addiction to: _____

☐ Other: _____

What operations have you had in the past? ☐ None

☐ Appendix removed	☐ Breast implants
☐ Tonsils removed	☐ Breast reduction surgery
☐ Gall bladder removed	☐ Breast biopsy
☐ Hernia repaired	☐ Breast lumpectomy
☐ Uterus removed (hysterectomy)	☐ Chest reconstruction
☐ Ovaries removed (oophorectomy)	☐ Other: _____

Other than for surgery or childbirth, have you ever been in the hospital overnight? ☐ Yes ☐ No

Has anyone in your family had any of the following? ☐ None

☐ Diabetes	☐ Thyroid problems	☐ Blood clots/diseases
☐ High cholesterol	☐ Osteoporosis	☐ Breast cancer
☐ High blood pressure	☐ Parkinson's disease	☐ Colon cancer
☐ Heart attack	☐ Alzheimer's disease	☐ Ovarian cancer
☐ Heart surgery	☐ Mental illness	☐ Prostate cancer
☐ Stroke	☐ Alcohol/drug addiction	☐ Other: _____

Are you allergic to any:

medications	☐ Yes	☐ No
foods	☐ Yes	☐ No
animals/insects	☐ Yes	☐ No

for office use only

What medicines (prescription and over-the-counter), vitamins, supplements and/or herbs do you take regularly? ☐ None

Name	*Dose*	*When do you take it?*	*What is it for?*

Do you often have trouble remembering to take medicines? ☐ Yes ☐ No

Have you ever gotten a period? ☐ unsure ☐Yes ☐ No
(skip to next section)

How old were you when you first got your period? _____

What was the date that your last normal period began? _____

What are your periods like?

I get one every _____ days.

It lasts for _____ days.

On my heaviest day, I use _____ maxi pads/tampons.

I get cramps with my period: ☐ Yes ☐ No

If yes, how severe are they on a scale of 1 (low) to 10 (high)?_____

Have you gone through menopause? ☐ unsure ☐Yes ☐ No
(skip to next section)

At what age? _____

Have you had any bleeding since then? ☐ Yes ☐ No

Have you ever taken hormone replacement? ☐ Yes ☐ No

Do you currently take hormone replacement? ☐ Yes ☐ No

If yes, what do you take?

☐ Estrogen/progesterone ☐ Estrogen alone

☐ Testosterone ☐ Other: _____

Are you having any symptoms of menopause? ☐ Yes ☐ No

If yes, which ones? ☐ Hot flashes ☐ Mood changes

☐ Vaginal dryness ☐ Insomnia

☐ other: _____

When was your last vaccine for:	*date*
HPV (Gardasil)	
Tetanus / TdaP	
Hepatitis A	
Hepatitis B	
Pneumonia (pneumovax)	
Chicken pox (varavax)	
Shingles (zostavax)	

Did you receive childhood vaccinations? ☐ No ☐ I'm not sure ☐Yes

Date: _____

Name _____ Birthdate _____ Chart No. _____

for office use only

When was the last time you had a test for tuberculosis (TB)? _____

Have you ever had a positive test for TB? ☐ Yes ☐ No

If yes, did you complete ≥ 6 months of preventative treatment? ☐ No ☐ Yes

If yes, which of the following symptoms do you have now? ☐ None

- ☐ cough > 3 weeks
- ☐ unexplained weight loss
- ☐ coughing up blood
- ☐ drenching night sweats

If no, have you had contact with someone known to have TB disease of the lung? ☐ Yes ☐ No

Were you born in Asia, Africa, Latin America, or Eastern Europe? ☐ Yes ☐ No

Have you spent more than 2 weeks in Asia, Africa, Latin America, or Eastern Europe in the past 2 years? ☐ Yes ☐ No

Have you been in prison/jail in the past 5 years? ☐ Yes ☐ No

Do you work with people who use drugs, are migrant workers, or are experiencing homelessness? ☐ Yes ☐ No

Are you a health care worker? ☐ Yes ☐ No

When was your last:	**Date**	**Result**	
HIV test			☐ unsure ☐ never
Sexually transmitted infection test			☐ unsure ☐ never
Hepatitis C test			☐ unsure ☐ never
Bone density test			☐ unsure ☐ never
Cholesterol test			☐ unsure ☐ never

When was your last:	**Date**	**Result**	
Cervical Pap smear			☐ unsure ☐ never
Was it ever abnormal?			☐ Yes ☐ unsure ☐ never
Anal Pap smear			☐ unsure ☐ never
Was it ever abnormal?			☐ Yes ☐ unsure ☐ never
Mammogram			☐ unsure ☐ never
Was it ever abnormal?			☐ Yes ☐ unsure ☐ never
Colorectal cancer			☐ unsure ☐ never
Was it ever abnormal?			☐ Yes ☐ unsure ☐ never

Which test(s) you've had: ☐ FOBT ☐ FIT ☐ Colonoscopy ☐ Other

When was the last time you saw a dentist? _____

How often in the past year have you had an alcoholic beverage?

- ☐ Daily or almost daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less than monthly
- ☐ Never

How often in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

- ☐ Daily or almost daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less than monthly
- ☐ Never

for office use only

Have you ever had sex with another person? ☐ Yes ☐ No
(skip to next section)

In your lifetime your sexual partner(s) have been: (check all that apply)
☐ women ☐ transgender FTM ☐ genderqueer
☐ men ☐ transgender MTF ☐ other: _____

Currently your sexual partner(s) are: (check all that apply) ☐ none
☐ women ☐ transgender FTM ☐ genderqueer
☐ men ☐ transgender MTF ☐ other: _____

When was the last time you had sex with another person? _____
In the past year, how many different sexual partner(s) have you had? _____
Currently, how many sexual partner(s) do you have? _____
Do you only have sex with each other? ☐ No ☐ Yes
Are you practicing "safer sex"? ☐ Never ☐ Sometimes ☐ Always
Do you think you or your sexual partner(s) may have a sexually transmitted infection right now? ☐ Yes ☐ No
Are you having any difficulties with your sex life? ☐ Yes ☐ No
Do you want to discuss this today? ☐ Yes ☐ No

What sexually transmitted infection(s) have you had in the past? ☐ None
☐ Gonorrhea ☐ Oral herpes
☐ Chlamydia ☐ Genital herpes
☐ Pelvic inflammatory disease ☐ Herpes through a blood test
☐ Syphilis ☐ Genital warts
☐ Trichomonas ☐ Other: _____

Have you ever been pregnant? ☐ Yes ☐ No
If yes, how many times have you been pregnant? _____
How many abortions? ____ How many premature births? ____
How many miscarriages? ____ How many full-term births? ____
How many live children do you have now? _____

Are you planning on getting pregnant? ☐ Yes ☐ No
If yes, when? _____

Do you or your partner(s) use any kind of birth control? ☐ No ☐ Yes
If yes, what kind? _____ ☐ Not needed
Are you satisfied with this method? ☐ No ☐ Yes

Could you or your partner(s) be pregnant today? ☐ Yes ☐ No
What would you do if you or your partner(s) got pregnant? ☐ N/A
_____

Have you ever been non-consensually hit, slapped, kicked, or otherwise physically hurt by an intimate partner? ☐ Yes ☐ No
If yes, when did this happen? _____
Do you want to discuss this today? ☐ Yes ☐ No
Have you ever been forced to have sexual activities against your will? ☐ Yes ☐ No
If yes, when did this happen? _____
Do you want to discuss this today? ☐ Yes ☐ No

Name _____ Birthdate _____ Chart No. _____